

Student Certification/Change

Eligibility requirements

To qualify for PEBB coverage, your student dependent must be:

- Age 20 through 23.
- Registered and attending classes at an accredited secondary school, college, university, vocational school, or school of nursing.

Certification period

Dependent student eligibility:

- Begins the first day of the month of the quarter or semester the student is enrolled and attending classes.
- Ends the last day of the month the student is in attendance or the last day of the month in which the quarter or semester ends, whichever comes first.
- Continues year-round for students who attend three of the four school quarters or two semesters.
- May continue up to three months after graduation as long as you are covered at the same time, the dependent has not reached age 24, and the dependent meets all other eligibility requirements (WAC 182-12-260(4)).
- Includes married children who qualify as your dependent under the Internal Revenue Code.

Instructions

- **The subscriber must complete this form.**
- **Type or print clearly in black ink. Inaccurate, incomplete, or illegible information may delay coverage.**
- **Do not fax this form if you are terminating coverage for your dependent.**
- Student eligibility for a dependent over the age of 20 is reviewed annually for the 12-month period following the month he or she was born. **The subscriber must complete and sign this form and submit it to the Health Care Authority (HCS) for review 30 days before the student dependent returns to school.**

You are responsible for notifying the Health Care Authority if there are any changes in the student's status throughout the year. For help with this form or for any questions on student status, please call 1-800-200-1004.

SECTION 1: Subscriber Information

If the information shown above is incorrect, please make the correction and notify your personnel, payroll, or benefits office so they can correct the information in your employee file.

Name	Social security number
Address	Phone Work () Home ()

SECTION 2: Dependent Information (Only one dependent per form)

Provide information for your dependent. **List one dependent per form.** If you are an active employee and your dependent's address is different than yours, please provide that information in this section and notify your personnel, payroll, or benefits office so they can update your dependent's address.

Dependent name	Address if different from subscriber
Social security number	Date of birth
Is this dependent married? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of marriage _____	
If yes, does this child qualify as your dependent under the Internal Revenue Code? <input type="checkbox"/> Yes <input type="checkbox"/> No	

(continued on back)

SECTION 3: Enrollment Information

If your dependent is a registered student, tell us the school's name, the city and state where it is located, and the registrar's phone number. If your dependent is currently enrolled, please list the quarters of semesters he or she is expected to attend for the next 12 months. If your dependent is not currently enrolled, provide the first quarter he or she will attend and the expected attendance for the following 12 months.

School name _____	City, State _____	Registrar's phone () _____	
Is your student dependent currently enrolled in school? <input type="checkbox"/> Yes <input type="checkbox"/> No Last quarter/semester attended (month/year) _____			
Expected school attendance for the 12 months following current enrollment			
QUARTER: <input type="checkbox"/> Fall Month/Year _____	<input type="checkbox"/> Winter Month/Year _____	<input type="checkbox"/> Spring Month/Year _____	<input type="checkbox"/> Summer Month/Year _____
SEMESTER: <input type="checkbox"/> Fall Month/Year _____	<input type="checkbox"/> Spring Month/Year _____	<input type="checkbox"/> Summer Month/Year _____	OTHER: _____
Starts _____ Month/year	Ends _____ Month/year	Expected graduation date _____ Month/year	
Note: Your dependent will be certified only for the attendance checked above. See eligibility requirements on the back of this form for information.			

SECTION 4: Notice of Qualifying Event/Request to Terminate Dependent's Coverage

You must provide written notice within 60 days after a qualifying event (such as a child's loss of dependent status). If the notice isn't provided in writing to PEBB Benefits Services within 60 days, your dependent will lose the right to elect COBRA or other continuation coverage.

When you notify PEBB about your child's loss of dependent status and PEBB Benefits Services requests it, you must provide satisfactory documentation of the qualifying event (for example, a marriage certificate to establish the date a child married or a transcript or other satisfactory evidence showing the last date of student enrollment).

If the student has graduation, he or she may be eligible for coverage for three months after graduation. Graduation is defined as the successful completion of studies to earn a degree/certificate, not the date of the graduation ceremony. If you do not want your dependent to be covered for the three-month period following graduation, please tell us in writing.

Complete only if your child is no longer eligible in accordance with the eligibility requirements shown on the back of this form. You must provide notice within **60 days** after the qualifying event. (See back for instructions.) Check the applicable box, then sign and date Section 5 below.

- ☐ My dependent is no longer eligible for PEBB coverage, effective _____ (month/day/year).
- ☐ My dependent has graduated; his or her graduation date was _____ (month/day/year).

SECTION 5: Subscriber Certification and Signature (Required)

You must complete this section. Your signature is required to authorize the enrollment recertification.

Insurance coverage is determined through verification of eligibility by the Washington State Health Care Authority (HCA). I have read the eligibility requirements on the back of this form, and I declare to the best of my knowledge and belief the information provided by me on this form is true and correct and all eligibility requirements have been met. I understand I may be subject to repayment of any claims paid by my health plan or premiums paid on my behalf if I have provided false, incomplete, or misleading information, or fail to update this information in accordance with eligibility guidelines. I understand that failure to provide accurate information or update information in accordance with PEBB rules may result in loss of coverage as of the last day of the month in which eligibility was met. A deposit of premium does not guarantee coverage and will be refunded if the dependent is determined to be ineligible for coverage. **I understand the HCA reserves the right to verify this information at any time.**

This form supersedes all forms and submissions I have previously made for PEBB coverage.

Print name _____

Signature (required) _____ Date _____

Mail completed form to:
Washington State Health Care Authority
P.O. Box 42684
Olympia, WA 98504-2684

Or fax to: 360-923-2602

This form must be mailed or hand-delivered if you are terminating coverage for your dependent.